THE MILITARY'S APPROACH TO THE REHABILITATION OF THE HEROIN ADDICT: A COMPARISON AND A CRITIQUE

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PREFACE

The thrust of this paper is toward the Military's handling of the Heroin addict. The rehabilitation of such a person has been the subject of much controversy in the Armed Forces. There is no intent of attempting to deal with the entire scope of the Military's approach to the rehabilitation of the drug user in general.

TABLE OF CONTENTS

INTRODUCTION.....1-2

I. THE MILITARY DRUG REHABILITATION PROGRAM.....2-5

II. CIVILIAN MODELS.....6-9

III. COMPARISON AND CRITIQUE.....9-12

IV. CONCLUSION.....12-14

BIBLIOGRAPHY.....15

CIVILIAN DRUG FACILITIES VISITED AND CONSULTED.....16

THE MILITARY DRUG REHABILITATION OF THE HEROIN ADDICT: A COMPARISON AND A CRITIQUE

By John W. Schumacher

INTRODUCTION:

In January of 1972 I was given the assignment at Fort Monmouth, New Jersey, of being the Staff Chaplain for the "Alchohol and Drug Abuse Program"--still in its most infant stages as far as the "rehabilitation" phase was concerned. I left the program after an involvement of six months due to re-assignment orders to another installation. Though my tenure may have been a short one in some respects, it none-the-less left some very deep and very lasting impressions upon me. Some of these impressions were good ones. Some left lingering questions. Others caused depression and frustration. Dealing with the heroin addict fell in the latter category. My education, though admittedly incomplete, was at the same time most illuminating.

Everyone knows that we're facing a problem of "epidemic proportions" (to use a near trite expression). It would serve no useful purpose here to quote supporting statistics. By now most are convinced that there is no sweeping cure for drug dependency. The legal pursuits in this area have attempted to be innovative and positive. Law Enforcement has taken a like approach, but treating drug abuse as a crime has had little or no impact on effecting a cure. Imprisonment or threats of such have acted on this problem with similar results. Even some in the field of Psychiatry have voiced near despair in attempting to find a viable, workable answer. To quote August Limkeman, an Army Chaplain who has made

a study of the problem: "widespread effective methods of dealing with this problem (or symptom) are just non-existant".[1]

Even in the face of such an overwhelming challenge, efforts to rehabilitate the addicted heroin user have been seemingly inexhaustable, and yet, in some measure there has been reported success. The United States Army has attempted a solution to its own drug abuse problem.

I. THE MILITARY DRUG REHABILITATION PROGRAM:

On the 17th of June 1971, President Nixon directed the Military Services that they would not thereafter discharge drug dependent servicemen back into society without first making every possible effort to rehabilitate them. The Military Services moved immediately to implement the orders of the President. An entirely new Army Regulation came into being within a few months in which directions were given to Military Commanders on how they would deal with the drug problem. This regulation (AR 600-32) stated very directly and very specifically that:

> The policy of the Department of the Army is to prevent and eliminate drug abuse and to attempt to restore and rehabilitate members who evidence a desire and a willingness to undergo such restoration.

Realizing the near formidable goal of "rehabilitating" drug addicts, Department of the Army, in a message to the Commanders in the Republic of Viet Nam (DA Message 2716372) in June of 1971, gave this direction:

> Drug abuse whether narcotics or alchohol, is often a chronic condition with occasional relapses. Therefore, the judgement of short term rehabilitation failure or success should

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[1]Limkeman, August, Chaplain (LTC), U.S. Army, Term Paper on "Drug Dependence", 17 March 1969, p. 13.

> not be conditioned on such absolutes as "cure", but on the basis of progress and estimated potential for improvement. This requires that the soldier be afforded a reasonable period to demonstrate his attitude toward rehabilitation. Decisions concerning adequate progress in rehabilitation normally should be made after the patient has been on post and in a therapeutic program for 60 days.

To further implement the President's message the United States Army began an effort grared to establish "therapeutic programs" on every major installation in the Continental United States and in selected areas of the overseas Commands.

As a means to reach the drug user, who until now was subject to criminal punishment for drug use, the Army offered "exemption" (previously called "amnesty"). This meant that the man who voluntarily turned himself in to his Commanding Officer as one genuinely seeking help for his problem whoud be protected from any legal proceedings relating to his abuse. This didnot, however, protect him from prosecution for drug related crimes. Department of Army policy in this regard was spelled out in DA Circular 1919522, July 1971:

> ...no soldier will be subject to any disciplinary action under the UCMJ or be discharged under other than honorable conditions solely on the basis of his examination and identification as a drug user. The same policy applies to a soldier who has volunteered for treatment under a command identification and treatment program, and who is not already implicated in drug related offenses.

The message goes on to emphasize the soldier is <u>not</u> free from military laws related to the sale or posession of drugs. Thus a strong incentive for a man to seek help for his drug problem was established. Admittedly, there were and are imperfections in this new approach, but it was a positive move and, for the most part, a good move.

Once the soldier had volunteered himself for help in dealing with his drug problem he then was referred to a rehabilitation program on his installation. The Army's approach to the actual establishment of a therapeutic program has not been uniform. Commanders were told to be innovative and the result has been a variety of approaches. No two programs are identical, and yet all follow some of the same basic guidelines. The length of the initial evaluation period is 60 days. Whether the drug dependent soldier who has volunteered for such a program is placed in a "live-in" situation or not depends on the installation. Some installations have abandoned the "line-in" approach while yet a number of others have adopted it.

I will not go into detail here as to how each center is set up. The variety is simply too great. The man who successfully completes his initial 60 day "in-depth" therapy program is normally released to an "outpatient" status where he will be further evaluated by written reports at the 120 and 180 day time intervals.

Admittedly, whether a man is rehabilitated or not is very subjective. What does rehabilitation mean? Webster's Dictionary gives this definition of the term: "To restore to a former capacity: re-instate, (or) restore to a good repute; vindicate."[2] But to apply this word as a part of evaluating an addicted drug user may be a very difficult and confusing task. Does it mean entirely drug-free, and, if so, for how long? Does it mean only

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[2]Webster's New Collegiate Dictionary, 1953 Edition, by G. & C. Merriam Co., The Riverside Press, Cambridge, Mass., U.S.A.

"good performance", or free from subsequent incrimination? To some it does mean this. Does it mean negative urinalysis screening reports, or that the individual has simply "stayed out of trouble" over a period of time? I am convinced that to some it means no more than this.

DA Circular 600-85, dated June 1972, has this to day about evaluating a man's rehabilitation progress (page G-1):

> Therefore, the judgement of success or failure should not be made on the basis of absolute "cure"; the soldier's attitude, performance of duty, and his estimated potential for further improvement should be the primary criteria.

This guideline will no doubt be interpreted in as many ways as there are Commanders who use it.

Detoxification has proven no real challenge. It is a medical matter and, through the use of the synthetic narcotic Methadone, the body can comfortably withdraw from its need for heroin in a matter of only 4 or 5 days. Following this initial period of rehabilitation is the period of prolonged therapy. And it is in this stage that the long, hard, sometimes futile, sometimes frustrating, rarely successful work of "rehabilitation" is attempted. So frustrating has this become to the Military that recommendations such as the following have been made:

> As an alternative to mandatory military rehabilitation some members recommended mandatory drug participation in civilian programs through excess leave.[3]

More will be said about this in the "Critique" section of this paper, but suffice it to say that the Military Services are recognizing their limitations in the area of rehabilitation.

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[3]First Army Drug and Alchohol Conference Report, 22-23 November 1971, page V-7.

II. CIVILIAN MODELS:

In order to clarify the dimension of the challenge before the military in dealing with drug (heroin) addiction it is both appropriate and important to look briefly at what is being attempted in the civilian community. Here I will attempt to summarize pertinent aspects of civilian drug rehabilitation programs as they appear to bear on the particular concern of this paper.

Possibly one of the greatest drug problem areas of our country is the Metropolitan New York City area and its surrounding communities including Northern New Jersey. It is claimed that New York City has 100,000 addicts, and that drug related incidents are the greatest cause of death in the 15 to 35 year age bracket.[4] Perhaps these figures do not entirely reflect the scope or the magnitude of the problem, but they are still most alarming.

To endeavor to cope in some measure with this dilemna the City of New York, under the "Youth Services Agency", lists some 20 Drug Rehabilitation programs.[5] Of these programs "Phoenix House" is perhaps the most extensive in its outreach. Its headquarters is located at 325 W. 8th Street and claims to be the "largest drug-free rehabilitation and re-education program on the East Coast".[6] Phoenix House is a three-phase program of Induction, Treatment, and Re-

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[4] Rosenthal, Mithchell S., "Phoenix House" "Pathways in Child Guidance", A Publ. of the Bureau of Child Gd., Bd of Ed., N.Y. June '71, p. 7.

[5] Youth Services Agency, New York City, Pamphlet on Drug Rehabilitation Facilities and Programs. n.d.

[6] Rosenthal, op. cit., p. 7.

Entry. The "Phoenix", the mythological bird that rises from its own ashes to a new life, seemed an appropriate choice for a name for this place of concern. They started on the second day of May in 1967 with only five men. In the intervening years the effort has grown now to 15 houses with more than a thousand residents.

Phoenix House offers a 3-year treatment program with at least 18 months of that time in residence at one of their centers. The "in-resident" portion offers a total live-in situation. Discipline is strict and retribution for rule breakers is swift and thorough. Some violations are considered cause for dismissal while others may mean "only" having the head shaved. "Encounter" is the very core of the rehabilitative effort.

> The encounter makes everything happen. If you took the encounter out of Phoenix, the houses would just be buildings and the program would die. It is the soul of the organization.[7]

Along with group encounter are, of course, other kinds of therapy and personal counseling. There is no effort to cater to the newcomer. The majority of the staff members are former addicts and, though able to cut through the "con-job" of a newcomer immediately, they serve also as a model of the fact that a man can not only get clean, but he can stay clean as well. Thus has Phoenix made its attempt to lift its residents "out of the ashes" into a new life.

Perhaps one of the most controversial of the civilian models is the program known as "Synanon". This program consists of groups of residents throughout the country all managed by ex-addicts. It is controversial because the rigid requirements to get into the

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[7]Rosenthal, op. cit., p. 9.

program include a rather heavy financial commitment on the part of a prospective resident which is not refundable if he leaves. It is also a known fact that the majority of those completing the program do not return to a normal life in the civilian community, but rather stay in the Synanon Rehabilitation effort as workers. Only those very highly motivated will be admitted. It is claimed however, that about half of those who complete the program do not return to drug use.

Synanon was started by Chuck Dederich, a member of Alchoholics Anonymous, in 1958 when he saw that some addicts were attending AA meetings as a means to help them stay off drugs. The program emphasizes "cold turkey" withdrawal from heroin--abrupt discontinuation of the drug use. It covers a period of 2½ years and also relies heavily on "encounter" therapy. The program has rigid rules and will not tolerate the presence of drugs or violence. Not even foul language is permitted except in encounter therapy where it is felt to be beneficial to the therapy process. No promiscuity is allowed nor is homosexuality, and breaking of the rules is automatic dismissal.

Other programs I have visited personally are "Dare" of Newark, New Jersey; "Discovery House", Marlboro State Hospital, North Central New Jersey; "Dysmas House", Patterson, New Jersey; and the "Teen Challenge" programs in New York City and Long Branch, New Jersey. All of these programs have some of the same foundation stones as the previously mentioned civilian models on which they have built their programs. Though they are unique and innovative in their approaches there are still basic agreements that are worth

noting. They agree 1) that the rehabilitative environment must be characterized by strict and rigid rules; 2) that the rehabilitative environment must also be a total "live-in" situation, and that it be drug free; and 3) that the period of rehabilitation effort cover a minimum of 9 or 10 months on up to 30 months. The Teen Challenge program, which relies heavily on dynamic Christian conversion and commitment, still agrees that prolonged therapy (a minimum of 9 months and in most cases up to 18 months) is absolutely vital to prepare an individual to lead a drug-free life in his or her community.

With the foregoing considerations in mind I would go back again to the Military Drug Rehabilitation effort and make what I feel to be some legitimate points of comparison and critique.

III. COMPARISON AND CRITIQUE:

When I move to a point of "comparison and critique" I realize that I am moving into perhaps a very sensitive area. The Army has worked long and hard and expended great resources in money, materiel, and manpower. Yet, in focusing again on our ability to deal with the heroin addict we do ourselves a great disservice not to consider some very obvious facts, and these become painfully apparent when we compare our efforts to those of the civilian community.

Here are some of those comparisons: 1) The rehabilitation environment, so critical to effective therapy, has very little change for the Military program. The patient, or "resident", is housed in a facility on the installation. In some cases he remains in his troop billets. For the most part he is as exposed to his former environment as before except that his off-duty time is scheduled

either partially or completely for him. Even here rules permit enough social intercourse so as to make his rehabilitation environment not significantly different. Whether or not this is a valid criticism is not the point. It is an obvious departure from what all civilian programs consider of vital importance. 2) Perhaps the most glaring difference is in the length of time alloted to the "in-depth" rehabilitation period. For the military man it is 60 days--perhaps a little longer, but not significantly so. The shortest time I have known to be characteristic of any civilian program is 9 months. Thus we see that possibly the two most important foundation stones for effective rehabilitation--a total control, "protected" environment, and an extended time period (9 to 18 months--even up to 30 months)--are missing from the Army's approach.

Attitude is another critical factor in effective rehabilitation efforts. The Army has what many observers would call an "official" attitude and an "unofficial" attitude. "Officially", the attitude is perhaps best expressed in these words from the "National War College Report":

> Drug abuse is a cultural problem--not a medical one. Its history has been to define it just as "criminal", then as "immoral", and recently as "sick". It cannot validly be defined in any of those ways. Disease is dirty by definition. We should regard drug addiction or abuse as "disease" and focus on making the sufferer healthy and whole again--approaching him with the same concern we would demonstrate for a person with a more socially acceptable disease.[8]

"Unofficially", there is an attitude present in the military community that runs counter to effective treatment. Perhaps the

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[8] U.S. Army Summary Report on the Army Worldwide Alchohol and Drug Conference, National War College, Washington, D.C., September 1971. p. 49.

most extreme example of this are statements made in my presence by senior officers in responsible positions who were openly hostile to any effort by the Army to treat addiction. Some of these men were directly responsible for the existing rehabilitation program. Chaplain Billy Lord, one of those who helped pioneer the rehabilitation effort in Viet Nam, had this to say in a speech given at a Drug Conference in Maryland in the Spring of 1972:

> When you face the question (How do we view the drug user?) ...a whole set of presuppositions and prejudices necessarily fall into place. It affects the way you deal with people, the way you treat them. It communicates itself to staff, patients, and others involved. The drug abuser will know how you view him.[9]

In some cases the Army has been bold enough to admit the attitude exists and that it does pose a significant problem. These quotes are from the "National War College Report":

> Commanding officers are by no means committed as a group.[10]

> Command attitudes are one of the biggest stumbling blocks the program has.[11]

> (Rigidness of attitude)...presents a major stumbling block to effective progress, especially where these individuals are in positions of direct authority over drug programs or resources.[12]

We have surely come far enough in our effort in the United States Military that we can gear our expectations more realistic-

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[9]Lord, Billy R., Chaplain (MAJ) U.S. Army, Report on "Lessons Learned from the Rehabilitation Effort in Viet Nam.

[10]U.S. Army Summary Report, op. cit., p. 61.

[11]Ibid.

[12]U.S. Army Summary Report, op. cit., p. 71.

ally. We must accept the fact that we do have limitations and not try to go beyond them. Some of these limitations have been noted. Civilian directors of rehabilitations programs have reacted to these limitations quite openly. One man, whom I deeply respect for his expertise in the area of rehabilitation, actually laughed out loud at the mention of any attempt to deal effectively with an addict in a period of 2 or 3 months. Another told me that even in the total control enviornment of his program there is not the slightest attitudinal change on the part of any resident until he has completed 3 or more months. The military has openly admitted this very fact:

> 1) Two or three months is inadequate...for effective rehabilitation of hard core drug dependents.
>
> 2) Present rehabilitation is beneficial for those who can utilize short term rehabilitation. (Underlining mine.)
>
> 3) Long term treatment/rehabilitation is impractical for (the) military community to undertake. (Underlining mine.)[13]

Perhaps the most realistic expectation of all is the following statement from the "National War College Report":

> It (the Army) should only be involved in identifying and detoxifying people for return to combat. Individuals needing further rehabilitative input should be separated.[14]

IV. CONCLUSION:

Can we effectively deal with the drug addict--the heroin addict--within the framework of the Army Rehabilitative effort? I say, no! We are not equipped attitudinally, and we are not

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[13] First United States Army, Alchohol and Drug Abuse Workshop, "After Action Report", 22-23 November 1971, p. v-16.

[14] United States Army Summary Report, op. cit., p. 64.

prepared (nor are we able in my opinion) to provide an environment of total control for a sufficient time period. Does this run counter to the direction of the President? Again, in my opinion, no. It is simply recognizing our limitations, and then making realistic adjustments so that we can carry out this aspect of our total mission.

The Army's most recent directive, D.A. Circular 600-85, has given this guidance to Commanders (Section 6., page 3):

> If an individual is a rehabilitative failure after about 60 days of treatment and if he is not facing criminal prosecution, precess him for separation under appropriate Army regulations. He should be transferred to a Veteran's Administration Hospital prior to discharge from the service.

Why is it necessary to wait 60 days before making a determination on a known heroin addict? If we are now willing to accept the advice of competant authorities as to the disposition of such a man at the end of a 60 day period why couldn't provision be made to consider the same matter in a much shorter period of time? The Army is admittedly committed to short term rehabilitative efforts, and yet, civilian authorities have seriously questioned the effectiveness of such an approach in dealing with the addict. It is my most sincere conviction that attempting to deal in <u>any</u> "curative" sense with such a case in so short a time is, in most cases, an exercise in futility. I would further propose that we take a look at a more realistic approach. Such an approach would be to allow competant military authorities (the Psychiatrist, the Social Worker, the Chaplain, and the man's unit Commander) to make an initial determination as to the "rehabilitative potential" of the individual. If there is a concensus that the potential is <u>negative</u> then authority

should be given the individual's Commander to begin immediate dismissal proceedings.

How we shall finally decide to deal with this reality simply cannot be worked out within the scope of this paper. I do offer this proposal, however, as something which whould be faced and considered as a viable part of out drug offensive. We have dodged it too long.

To recognize our limitations is not to in any way fault the many dedicated workers in the field of the treatment and rehabilitation of the drug abuser. To some segments of this problem we still have much to offer. We must, however, face up to the reality that neither we no anyone else has found the solution in dealing with heroin addiction. We must face what we shall do, and honestly evaluate, at all levels of the military community, what are our real attitudes and resources in dealing with the man and his problem. We must then find an honest, feasible, and realistic path of action in dealing with him--even if that means immediate separation from military service of those deemed to be of negative rehabilitative potential.

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